Sins of youth

James Welsh

Just to the right of my computer screen, pinned on the wall, is a small poster with photographs of eight young Americans—four black and four white—united by events in their teenage years. In the top left is Troy Dugar from Louisiana. He stands wearing a loose overall with his hands clasped in front of him. He looks blankly at the camera and at me. Troy is mentally ill. Moving round the poster clockwise, Gary Davies Hart from Alabama is photographed in near profile and looks like a smart young attorney's clerk, his glasses contributing to an air of seriousness.

The late Jay Pinkerton, a Texan, is shown full face photographed in mid-word. Below him on the poster is the late Dalton Prejean, looking like a streetwise black young man in a training jacket and woollen hat. Heath Wilkins is the most confident looking person of the eight despite his history of severe abuse as a child. He stands in the Missouri sunshine in singlet, shorts, and trainers, with arms folded across a muscular chest. Sixteen year old Paula Cooper of Indiana is shown full face, a black young woman with short plaited hair. Clayton Flowers, photographed in medium frame, seems to be biting his lower lip. He could be apprehensive or showing a steely disregard for what was happening. Someone has a hand around his arm.

Sean Sellers looks like an angelic boy scout though he is psychotic. His lack of angelic qualities is betrayed by the handcuffs he wears. In fact, none of the above named people are, or were, angels. All of them were convicted of murder, some particularly grisly. They carried out these crimes between the ages of 15 and 17. Apart from Pinkerton and Prejean, who have been executed, all are currently in prison. Sellers and Wilkins remain on death row. Flowers, Dugar, Hart, and Paula Cooper are no longer under sentence of death (though Flowers is sentenced to remain in prison until he dies).

Currently there are 40 prisoners under sentence of death in the United States who were juveniles at the time of the crime. The United States is one of the few countries in the world which executes juveniles, along with states such as Iran, Iraq, Pakistan, and the Yemen; it executes them at a higher rate than has been documented in any other country.

What does this have to do with the medical profession? Potentially quite a lot. The death penalty industry in the United States is possibly the most heavily medicalised in the world. Probably most of the other countries which might be tempted to involve medical professionals in this gruesome business have abolished capital punishment. Evidence relating to mental competence, future dangerousness, as well as preparation of lethal chemicals, supervising the use of execution technology, and monitoring the execution all have the potential to involve doctors.

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The American Medical Association (AMA) has prohibited virtually all involvement by doctors in executions but it remains to be seen how effective this proscription will be in practice. Last year a prison doctor in Virginia who refused to be present at an execution was threatened with demotion by the prison authorities, including being sent to a small country prison. In Illinois doctors who participate in executions in breach of AMA guidelines are protected by legislation introduced by the state government to protect the identity of personnel carrying out an execution.

It is difficult to think of any other procedure carried out by a doctor acting in a public function which requires a law to keep that doctor's identity hidden from even the medical ethics committee of a professional association. Even worse, recent legislation adopted in Illinois defines the medical role at

executions as being a non-medical role, legally outside the application of the Medical Practice Act and by implication outside the scope of medical ethics. While it is true that killing prisoners at the behest of the state is not the role of medicine, it does not follow that doctors who do assist executioners are honorary non-doctors untouched by medical ethics.

I look again at the poster: eight young people who had such a devastating impact on the lives of their victims and families. Eight marginalised, brain damaged, mentally handicapped, substance abusing, or antisocial youths: losers in a country which prizes winners. But executing them solves no problems. It breaches international standards; it risks involving the medical profession in unethical activities; it creates yet more bereaved families; and it sends out a clear message that violent crime needs a violent response. And that is not to address the appalling prospect that one or more might be innocent. There is no suggestion in the eight cases cited here that any miscarriage of justice has occurred, but it is virtually certain that in the past innocent prisoners in the United States have—as in Britain—been executed. None of these aspects of capital punishment appear particularly wise risks to run.

Medical associations should ensure that their members do not assist in executions and should call for public policy which really addresses crime rather than sending a small number of poor, minority, or mentally handicapped prisoners to a miserable and demeaning (and usually long delayed) death: a fraudulent but apparently popular course of action which will not have the least impact on the problem of violent crime.

On 31 October 1995 there were approximately 3000 prisoners on death row in the United States. At the current rate of execution it would take anywhere between 50 and 100 years to execute them all, assuming that they had a long life and that no further prisoners were sentenced to death. We can safely assume that state governments in the United States are anxious to see an increase in the execution rate.—JAMES WELSH is coordinator of Amnesty International's medical programme

The view from the queue

Teifion Davies

"Where's Danny?" The words were out before I was conscious of what prompted them. My wife and older son were waiting for me as I emerged from the customs hall at Heathrow airport, but my accident prone younger son was prominently absent. I had been lecturing

at a medical school in the Middle East for a week and as I waited in the queues at Heathrow anxiety about my family, and Danny in particular, had begun nagging at the back of my mind.

A month later I took Danny for his follow up appointment at the fracture clinic of our local hospital. The fracture of his clavicle, caused during a wicked stunt involving a mountain bike and a large log, was healing without problems and there was no reason to expect any hitches at the clinic. We live within half a mile of the hospital and arrived early. The receptionist took Danny's appointment card in a rather absentminded way and asked us to sit down. At that moment, the notes

trolley entered the clinic and Danny's appointment card—in fact, our entire existence was forgotten.

I was not aware that we had been overlooked. I was unaware, too, that the receptionist's error was to afford me an experience rarely gained by doctors: I sat in the waiting room throughout an entire out-patient clinic. Fracture clinics are very much like any other clinic, including my own: always busy, often overbooked, and frequently interrupted and delayed by a half expected or totally unforeseen circumstance. This was no exception, but we were well prepared. I had packed a carrier bag of amusements: a selection of games, several toy figures, half a